

REPORT OF THE BOARD OF TRUSTEES

B of T Report 19 – I-05

Subject: Medicare Physician Voluntary Reporting Program

Presented by: Duane M. Cady, MD, Chair

Referred to: Reference Committee J  
(Iffath A. Hoskins, MD, Chair)

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1 BACKGROUND

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3 On October 28, 2005, the Centers for Medicare and Medicaid Services (CMS) announced that it  
4 will implement a “Physician Voluntary Reporting Program” (PVRP) beginning in January 2006.  
5 The PVRP is intended to allow physicians who choose to participate to submit quality  
6 information on Medicare claims and be able to receive feedback on their performance as early as  
7 the summer of 2006. The program would add to existing CMS quality initiatives that provide  
8 information on the quality of care across different settings, including hospitals, skilled nursing  
9 facilities, home health agencies, and dialysis facilities for end stage renal disease. Physician  
10 participation in the PVRP is not linked to Medicare reimbursement.

11  
12 Earlier this year the AMA hosted meetings between specialty and CMS staff to express concerns  
13 and suggestions regarding the PVRP concept. A conceptual pay-for-reporting/performance  
14 framework agreed to by over 70 medical organizations was shared with CMS. In addition, the  
15 AMA engaged CMS in a variety of settings throughout the year related to performance measure  
16 development, endorsement, and implementation via the AMA-convened Physician Consortium  
17 for Performance Improvement (Consortium), National Quality Forum (NQF), and Ambulatory  
18 Care Quality Alliance (AQA). Despite this engagement, CMS heeded very little advice from the  
19 medical community in the final PVRP.

20  
21 MEASURES

22  
23 A full list of measures that will be implemented as part of this initiative is included at the end of  
24 this report. Although CMS Administrator Mark B. McClellan, M.D., Ph.D., in his testimony  
25 before the House Ways and Means Subcommittee on Health on September 29, 2005 stated that  
26 CMS originally intended to use 66 measures for this program, CMS reduced the final number to  
27 36 covering approximately 23 specialties. The final measures were roughly derived from the  
28 following sources: Sixteen from existing physician level performance measures (including eight  
29 Consortium measures and five National Committee for Quality Assurance measures), thirteen  
30 hospital level measures converted to physician level measures by CMS (including a few Surgical  
31 Care Improvement Project measures), and seven measures from RAND and others. Additional  
32 quality measures are under development and could be phased-in for reporting later in 2006.

33  
34 G-CODES AS A REPORTING MECHANISM

35  
36 CMS will use G-codes on the physician claim as an interim reporting mechanism until electronic  
37 submission of clinical data through EHRs replaces this process. CMS stated it is working with

1 physicians to achieve the goal of adopting EHRs in their offices and that building on this pre-  
2 existing claims based PVRP system will minimize the burden on physicians in the long term.  
3 CMS contracted Quality Improvement Organizations (QIOs) will provide assistance to physicians  
4 to help them create systems so the measures can be more easily reported in the future.  
5

6 AMA ISSUES/CONCERNS

- 7
- 8 • Uncertain potential to improve quality
  - 9 • Uncertainty of physician payment updates in the near future
  - 10 • Effect on Medicare physician volume under the SGR
  - 11 • Administrative burden/cost of G-code reporting
  - 12 • Disproportionate burden on certain specialties (e.g., primary care)
  - 13 • Accuracy and usefulness of data
  - 14 • Validity of certain measures (e.g., use of hospital level measures for physicians)
  - 15 • Lack of use of CPT Category II codes, where available
  - 16 • Future CMS uses of PVRP data (e.g., public reporting)
  - 17 • Potential negative public perception if physicians do not volunteer
  - 18 • Misalignment with private sector initiatives (e.g., Specialty Board Maintenance of  
19 Certification)

20

21 RECOMMENDATIONS

- 22
- 23 1. RESOLVED, That our AMA continue to communicate our strong objections to CMS's  
24 Physician Voluntary Reporting Program, and be it further  
25
  - 26 2. RESOLVED, That our AMA work with other Federation organizations to express organized  
27 medicine's strong concerns on the proposed implementation of the Physician Voluntary  
28 Reporting Program and to offer our assistance to rectify deficiencies in the program.  
29

30 ATTACHMENTS

- 31
- 32 A. Letter the AMA sent to Administrator McClellan
  - 33 B. Final list as released by CMS on November 2, 2005 of G-Code Specifications

## FINAL MEASURES (Measure Descriptions)

Aspirin at arrival for acute myocardial infarction
Beta blocker at time of arrival for acute myocardial infarction
Antibiotic administration timing for patient hospitalized for pneumonia
Hemoglobin A1c control in patient with Type I or Type II diabetes mellitus, age 18-75
Low-density lipoprotein control in patient with Type I or Type II diabetes mellitus, age 18-75
High blood pressure control in patient with Type I or Type II diabetes mellitus, age 18-75
Angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker therapy for left ventricular systolic dysfunction
Beta-blocker therapy for left ventricular systolic dysfunction
Beta-blocker therapy for patient with prior myocardial infarction
Antiplatelet therapy for patient with coronary artery disease
Low-density lipoprotein control in patient with coronary artery disease
Osteoporosis screening in elderly female patient
Screening of elderly patients for falls
Screening of hearing acuity in elderly patient
Screening for urinary incontinence in elderly patients
Dialysis dose in end stage renal disease patient
Hematocrit level in end stage renal disease patient
Receipt of autogenous arteriovenous fistula in end-stage renal disease patient requiring hemodialysis
Warfarin therapy in patient with heart failure and atrial fibrillation
Smoking cessation intervention in chronic obstructive pulmonary disease
Prescription of calcium and vitamin D supplements in osteoporosis
Antiresorptive therapy and/or parathyroid hormone treatment in newly diagnosed osteoporosis
Bone mineral density testing and osteoporosis treatment and prevention following osteoporosis associated nontraumatic fracture
Annual assessment of function and pain in symptomatic osteoarthritis
Influenza vaccination
Mammography
Pneumococcal vaccination
Antidepressant medication during acute phase for patient diagnosed with new episode of major depression
Antidepressant medication duration for patient diagnosed with new episode of major depression
Antibiotic prophylaxis in surgical patient
Thromboembolism prophylaxis in surgical patient
Use of internal mammary artery in coronary artery bypass graft surgery
Pre-operative beta blocker for patient with isolated coronary artery bypass graft
Prolonged intubation in isolated coronary artery bypass graft surgery
Surgical re-exploration in coronary artery bypass graft surgery
Aspirin or clopidogrel on discharge for isolated coronary artery bypass surgery patient



Attachment A

November 3, 2005

Mark B. McClellan, MD, PhD  
Administrator  
Centers for Medicare and Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Ave., SW  
Room 314-G  
Washington, DC 20201

Dear Dr. McClellan:

On behalf of the American Medical Association (AMA), we express our strong objection to the "Physician Voluntary Reporting Program" (PVRP) as announced by the Centers for Medicare and Medicaid Services (CMS) on October 28. We have repeatedly demonstrated our commitment to provide the highest quality care for our Medicare patients. We have also demonstrated our commitment to work with CMS to create evidence-based, physician-developed measures to improve the quality of care for our patients. However, we have serious concerns regarding the PVRP and its ability to achieve its stated quality goals. The excessive administrative requirements that this program will impose on physicians could doom this initiative and negate any intended quality improvements.

The physician community has made a good faith effort to develop, endorse, and implement physician performance measures. These efforts have been accomplished through the work of individual medical organizations, as well as through participation with CMS in collective efforts such as the Physician Consortium for Performance Improvement (Consortium), National Quality Forum (NQF), Ambulatory Care Quality Alliance (AQA), and Performance Measurement Advisory Group to the CPT Editorial Panel.

Within a week of announcing the PVRP, CMS formally announced that Medicare will cut reimbursement to physicians by 4.4%, the first of multiple cuts totaling 26% over the next six years. These cuts have the potential to severely limit seniors' access to the Medicare program. We have joined Congress in repeatedly urging the Administration to take administrative action to increase funding for physicians' services and facilitate enactment of legislation to replace the SGR with payment updates based on physicians' practice cost increases. The Administration has failed to meet its obligations to ensure Medicare patients' access to quality care by refusing to administratively adjust the SGR.

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In the PVRP, CMS has bypassed a significant body of collaborative work in favor of its own reporting program. For example, one of the key goals of the AQA, an alliance in which CMS actively participates, is to implement performance measures in a uniform manner across the private and public sectors to improve quality and limit the reporting burden on physicians and other providers. The PVRP achieves the opposite by using temporary G-codes to report a handful of valid physician measures, along side hospital level measures rewritten by CMS and other private sector measures in a proprietary CMS program.

Under the PVRP, a primary care specialist treating a 70 year old woman with the relatively common conditions of osteoporosis, diabetes, and heart disease would have to report an estimated 12-13 measures and consider 36-39 potential G-codes. Physicians practicing in the inpatient setting face the significant problem of not being able to attribute care delivered within a hospital system back to the individual physician level for accurate and reliable performance measurement.

Initial indications from practice administrators are that few if any practice management and EHR systems are ready to facilitate participation in this program. There are also indications that practices will have to contract with software vendors for updates, which would add significant new costs to their overhead. Even then, many practices report that a number of software vendors would be unlikely to rewrite their programs within the next year. This was the case during the implementation of the Health Insurance Portability and Accountability Act, when many medical practices stopped submitting claims directly to CMS and began sending them to clearinghouses at additional cost because software vendors would not write updates in time to comply with federal laws.


In numerous meetings and communications to CMS, physician medical organizations have expressed concern over the dire Medicare physician payment outlook and repeatedly offered suggestions regarding the concept of implementing a physician quality reporting system in Medicare. In CMS' haste to implement the PVRP by January 2006, most of these concerns and suggestions were not heeded.


We strongly urge you to rescind this project. In addition, we recommend a fresh start on future CMS quality activities starting with a meeting between you and physician leaders that leads to meaningful dialogue.


Sincerely,


American Medical Association Board of Trustees


McClellan  
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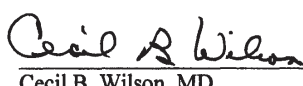
  
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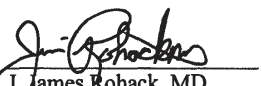
  
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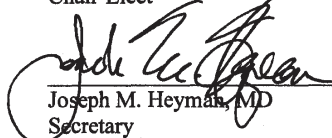
  
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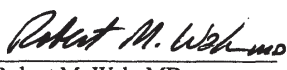
  
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**G-Code Specifications and Instruction for Clinical Measures  
Physician Voluntary Reporting Program (PVRP)  
As of: November 1, 2005**



Numerator:

**G8006:** Acute myocardial infarction: patient documented to have received aspirin at arrival

**G8007:** Acute myocardial infarction: patient not documented to have received aspirin at arrival

**G8008:** Clinician documented that acute myocardial infarction patient was not an eligible candidate to receive aspirin at arrival measure

Denominator:

*Patients with acute myocardial infarction who present to hospital emergency department or are hospitalized as listed:*

Patients with acute myocardial infarction:

ICD-9: 410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91

**And**

ED E&M: 99281-99285; initial hospital care E&M: 99221-99223; observation: 99218-99220, 99234-99236; critical care services: 99291- 99292

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed CPT services are provided for a patient with acute myocardial infarction. It is anticipated that the patient would receive aspirin therapy upon initial arrival if clinically appropriate. However, the timeframe for this measure includes the entire 24 hour period before presentation and the 24 hour period from the time of presentation. This construct is consistent with the hospital performance measure. This measure is intended to reflect the quality of services provided for the initial, primary management of patients with acute myocardial infarction who present to the emergency department or the hospital setting.



Numerator:

**G8009:** Acute myocardial infarction: patient documented to have received beta-blocker at arrival

**G8010:** Acute myocardial infarction: patient not documented to have received beta-blocker at arrival

**G8011:** Clinician documented that acute myocardial infarction patient was not an eligible candidate for beta-blocker at arrival measure

Denominator:

*Patients with acute myocardial infarction who present to hospital emergency department or are hospitalized as listed:*

Patients with acute myocardial infarction:

ICD-9: 410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91

**And**

ED E&M: 99281-99285; initial hospital care E&M: 99221-99223; observation: 99218-99220, 99234-99236; critical care services: 99291- 99292

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed CPT services are provided for a patient with acute myocardial infarction who presents to the hospital emergency department or other hospital setting. It is anticipated that the patient would receive beta-blocker therapy upon initial arrival if clinically appropriate. However, the timeframe for this measure includes the entire 24 hour period from the time of presentation. This construct is consistent with the hospital performance measure. This measure is intended to reflect the quality of services provided for the initial, primary management of patients with acute myocardial infarction in the emergency department or hospital setting.

Numerator:

**G8012:** Pneumonia: patient documented to have received antibiotic within 4 hours of presentation

**G8013:** Pneumonia: patient not documented to have received antibiotic within 4 hours of presentation

**G8014:** Clinician documented that pneumonia patient was not an eligible candidate for antibiotic within 4 hours of presentation measure

Denominator:

*Patients with pneumonia as listed:*

ICD-9CM codes: 480.1, 480.2, 480.3, 480.8, 480.9, 481 (S. pneumo), 482.0 (Klebsiella), 482.1 (Pseudomonas), 482.2 (H. flu), 482.30 (unspec. Strep), 482.31 (Strep A), 482.32 (Strep B), 482.39 (other Strep), 482.40 (unspec. Staph), 482.41(S. aureus), 482.49 (other Staph), 482.81 (Anaerobes), 482.82 (E. coli), 482.83 (other gram neg), 482.84 (Legionnaires), 482.89 (other spec. bacteria), 482.9 (unspec. bacteria), 483.0 (M. pneumoniae), 483.1 (Chlamydia), 483.8 (other spec. organism), 485 (Bronchopneumonia, unspec. organism), 486 (unspec organism), 487.0 (influenza with pneumonia)

**And**

ED E&M: 99281-99285; initial hospital care E&M: 99221-99223, 99218-99220; critical care codes 99291-99292

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 is used with the listed CPT services for a patient with pneumonia. This measure should reflect the quality of services for the initial management of a patient with pneumonia presenting to the emergency department

and admitted to hospital or a hospital setting. Patients transferred to an emergency department should not be considered an eligible candidate and the clinician should use the appropriate quality G-code indicator to indicate that such a patient is not a candidate for this measure.

**Numerator:**

**G8016:** Diabetic patient with most recent hemoglobin A1c level (within the last 6 months) documented as less than or equal to 9%

**G8015:** Diabetic patient with most recent hemoglobin A1c level (within the last 6 months) documented as greater than 9%

**G8017:** Clinician documented that diabetic patient was not eligible candidate for hemoglobin A1c measure

**G8018:** Clinician has not provided care for the diabetic patient for the required time for hemoglobin A1c measure (6 months)

**Denominator:**

*Patients with diabetes:*

ICD-9-CM codes 250.0-250.9 (DM), 357.2 (polyneuropathy in DM), 362.0 (DM retinopathy), 366.41 (DM cataract), 648.0 (DM in pregnancy, not gestational)

**And**

E&M visit: 99201-99205, 99211-99215 (E&M); 99341-99350 (home visit); 99304-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary); G0344

**Instructions:**

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed E&M services are provided to patients with diabetes mellitus for the primary management of diabetes mellitus. It is not anticipated that clinicians would use this indicator if the clinician is not providing services for the primary management of diabetes mellitus.

**Numerator:**

**G8020:** Diabetic patient with most recent low-density lipoprotein (within the last 12 months) documented as less than 100 mg/dl

**G8019:** Diabetic patient with most recent low-density lipoprotein (within the last 12 months) documented as greater than or equal to 100 mg/dl

**G8021:** Clinician documented that diabetic patient was not eligible candidate for low-density lipoprotein measure

**G8022:** Clinician has not provided care for the diabetic patient for the required time for low-density lipoprotein measure (12 months)

Denominator:

*Patients with diabetes:*

ICD-9-CM codes 250.0-250.9 (DM), 357.2 (polyneuropathy in DM), 362.0 (DM retinopathy), 366.41 (DM cataract), 648.0 (DM in pregnancy, not gestational)

**And**

E&M visit: 99201-99205, 99211-99215 (E&M); 99341-99350 (home visit); 99304-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary)

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed E&M services are provided to patients with diabetes mellitus for the primary management of diabetes mellitus. It is not anticipated that clinicians would use this indicator if the clinician is not providing services for the primary management of diabetes mellitus.

Numerator:

**G8024:** Diabetic patient with most recent blood pressure (within the last 6 months) documented less than 140 systolic and less than 80 diastolic

**G8023:** Diabetic patient with most recent blood pressure (within the last 6 months) documented as equal to or greater than 140 systolic or equal to or greater than 80 mmHg diastolic

**G8025:** Clinician documented that the diabetic patient was not eligible candidate for blood pressure measure

**G8026:** Clinician has not provided care for the diabetic patient for the required time for blood measure (within the last 6 months)

Denominator:

*Patients with diabetes:*

ICD-9-CM codes 250.0-250.9 (DM), 357.2 (polyneuropathy in DM), 362.0 (DM retinopathy), 366.41 (DM cataract), 648.0 (DM in pregnancy, not gestational)

**And**

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99341-99350 (home visit); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary); G0344

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed E&M services are provided to patients with diabetes mellitus for the primary management of diabetes mellitus.



Numerator:

**G8027:** Heart failure patient with left ventricular systolic dysfunction (LVSD) documented to be on either angiotensin-converting enzyme-inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy

**G8028:** Heart failure patient with left ventricular systolic dysfunction (LVSD) not documented to be on either angiotensin-converting enzyme-inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy

**G8029:** Clinician documented that heart failure patient was not an eligible candidate for either angiotensin-converting enzyme-inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy measure

Denominator:

*Heart failure patients with LVEF < 40% or with moderately or severely depressed left ventricular systolic function:*

Patients with heart failure:

Hypertensive heart disease with Heart failure: 402.01, 402.11, 402.91; Hypertensive heart and renal disease with Heart failure: 404.01, 404.03, 404.11, 404.13, 404.91, 404.93; Heart Failure codes: 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9

**And**

Patients who had documentation of an ejection fraction < 40% (use most recent value) or moderately or severely depressed left ventricular systolic function

**And**

E&M visit: 99201-99205, 99211-99215 (E&M); 99341-99350 (home visit); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary)

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed E&M services visit are provided to patients with heart failure and decreased left ventricular systolic function. The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment. Examples of a quantitative or qualitative assessment would be an echocardiogram that provides a numerical value of left ventricular systolic dysfunction or that uses descriptive terms such moderate or severely depressed left ventricular dysfunction. This measure is intended to reflect the quality of services provided for the primary management of patients with heart failure.



Numerator:

**G8030:** Heart failure patient with left ventricular systolic dysfunction (LVSD) documented to be on beta-blocker therapy

**G8031:** Heart failure patient with left ventricular systolic dysfunction (LVSD) not documented to be on beta-blocker therapy

**G8032:** Clinician documented that heart failure patient was not eligible candidate for beta-blocker therapy measure

Denominator:

*Heart failure patients with left ventricular ejection fraction (LVEF) < 40% or with moderately or severely depressed left ventricular systolic function*

Patients with heart failure:

Hypertensive heart disease with Heart failure: 402.01, 402.11, 402.91; Hypertensive heart and renal disease with Heart failure: 404.01, 404.03, 404.11, 404.13, 404.91, 404.93; Heart Failure codes: 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9

**And**

Patient who has documentation of an LVEF < 40% (use most recent value) or moderately or severely depressed left ventricular systolic function

**And**

E&M visit: 99201-99205, 99211-99215 (E&M); 99341-99350 (home visit); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary)

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and E&M services are provided for a patient with documented left ventricular systolic dysfunction. The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment. This measure is intended to reflect the quality of services provided for the primary management of patients with heart failure.

Numerator:

**G8033:** Prior myocardial infarction - coronary artery disease patient documented to be on beta-blocker therapy

**G8034:** Prior myocardial infarction - coronary artery disease patient not documented to be on beta-blocker therapy

**G8035:** Clinician documented that prior myocardial infarction - coronary artery disease patient was not eligible candidate for beta-blocker therapy measure

Denominator:

*Patients with coronary artery disease who also have prior MI at any time as listed:*

Patients with Coronary artery disease:

414.00-414.07, 414.8, 414.9, 410.00-410.92 (Acute myocardial infarction), 412 (old MI), 411.0-411.89, 413.0-413.9 (angina), V45.81 (Aortocoronary bypass status), V45.82 (PTCA status)

**And**

E&M visit: 99201-99205, 99211-99215 (E&M); 99341-99350 (home visit); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary)

**And**

Patients with prior MI:  
410.00-410.92, 412

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to patients with documented coronary artery disease and prior myocardial infarction. This measure is intended to reflect the quality of services provided for the primary management of patients with coronary artery disease.

Numerator:

**G8036:** Coronary artery disease patient documented to be on antiplatelet therapy

**G8037:** Coronary artery disease patient not documented to be on antiplatelet therapy

**G8038:** Clinician documented that coronary artery disease patient was not eligible candidate for antiplatelet therapy measure

Denominator:

Patients with coronary artery disease:  
ICD-9-CM codes for Coronary artery disease: 414.00-414.07, 414.8, 414.9, 410.00-410.92 (Acute myocardial infarction); 412 (old MI), 411.0-411.89, 413.0-413.9 (angina), V45.81 (Aortocoronary bypass status), V45.82 (PTCA status)

**And**

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99341-99350 (home visit); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary)

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used with the listed E&M services provided for a patient with coronary artery disease. This measure is intended to reflect the quality of services provided for the management of patients with coronary artery disease. Antiplatelet therapy consists of aspirin, clopidogrel, or combination of aspirin and dipyridamole.

Numerator:

**G8040:** Coronary artery disease – patient with low-density lipoprotein documented to be less than or equal to 100mg/dl

**G8039:** Coronary artery disease – patient with low-density lipoprotein documented to be greater than 100mg/dl

**G8041:** Clinician documented that coronary artery disease patient was not eligible candidate for low-density lipoprotein measure

**G8182:** Clinician has not provided care for the cardiac patient for the required time for low-density lipoprotein measure (6 months)

Denominator:

*Patients with coronary artery disease:*

ICD-9-CM codes for coronary artery disease: 414.00-414.07, 414.8, 414.9, 410.00-410.92 (Acute myocardial infarction), 412 (old MI), 411.0-411.89, 413.0-413.9 (angina), V45.81 (aortocoronary bypass status), V45.82 (PTCA status);

**And**

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99341-99350 (home visit); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary)

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the CPT services are provided for a patient with coronary artery disease. This measure is intended to reflect the quality of services provided for the management of patients with coronary artery disease.

Numerator:

**G8051:** Patient (female) documented to have been assessed for osteoporosis

**G8052:** Patient (female) not documented to have been assessed for osteoporosis

**G8053:** Clinician documented that (female) patient was not an eligible candidate for osteoporosis assessment measure

Denominator:

*Female patients 75 years of age or older:*

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99304-99306, 99307-99310 (nursing facility); 99341-99350 (home visit)

**And**

Female patients 75 years of age or older

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to geriatric patients. This indicator, as well as other indicators related to assessments, should be provided only on an annual basis. It is anticipated that the clinical assessment would include counseling the patient about the risk of osteoporosis and the potential need for preventive therapy.

**Numerator:**

**G8055:** Patient documented for the assessment for falls within last 12 months

**G8054:** Patient not documented for the assessment for falls within last 12 months

**G8056:** Clinician documented that patient was not an eligible candidate for the falls assessment measure within the last 12 months

**Denominator:**

*Patients 75 years of age or older:*

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99341-99350 (home visit); 99304-99306, 99307-99310 (nursing facility); G0344

**And**

Patients 75 years of age or older

**Instructions:**

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to geriatric patients. This indicator, as well as other indicators related to assessments, should be provided only on an annual basis. It is anticipated that the clinical assessment would include annual review of the patient's fall history as part of a medically necessary visit.

**Numerator:**

**G8057:** Patient documented to have received hearing assessment

**G8058:** Patient not documented to have received hearing assessment

**G8059:** Clinician documented that patient was not an eligible candidate for hearing assessment measure

**Denominator:**

*Patients 75 years of age or older:*

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99304-99306, 99307-99310 (nursing facility); 99341-99350 (home visit); G0344

**And**

Patients 75 years of age or older

**Instructions:**

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to geriatric patients. This indicator, as well as other indicators related to assessments, should be provided only on an annual basis. It is anticipated that the clinical assessment would include an annual clinical examination and history of hearing capacity as part of a medically necessary visit.



Numerator:

**G8060:** Patient documented for the assessment of urinary incontinence

**G8061:** Patient not documented for the assessment of urinary incontinence

**G8062:** Clinician documented that patient was not an eligible candidate for urinary incontinence assessment measure

Denominator:

*Patients 75 years of age or older:*

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99304-99306, 99307-99310 (nursing facility); 99341-99350 (home visit); G0344

**And**

Patients 75 years of age or older

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to geriatric patients. This indicator, as well as other indicators related to assessments, should be provided only on an annual basis. It is anticipated that the clinical assessment would include annual history of patient's absence or presence of urinary incontinence.



Numerator:

**G8075:** End-stage renal disease patient with documented dialysis dose of URR greater than or equal to 65% (or Kt/V greater than or equal to 1.2)

**G8076:** End-stage renal disease patient with documented dialysis dose of URR less than 65% (or Kt/V less than 1.2)

**G8077:** Clinician documented that end-stage renal disease patient was not an eligible candidate for URR or Kt/V measure

Denominator:

*Patients with end-stage renal disease on hemodialysis as listed:*

CPT: G0308-G0327, 90945, 90947

**Or**

585.6 (End-stage renal disease)

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services or ICD-9 are provided and the listed hemodialysis CPT services are provided to patients with end stage

renal disease. This measure is anticipated to reflect the services provided for the primary management of end stage renal disease. It is not anticipated that this measure would be applicable for services not related to the primary management of end stage renal disease.



Numerator:

**G8078:** End-stage renal disease patient with documented hematocrit greater than or equal to 33 (or hemoglobin greater than or equal to 11)

**G8079:** End-stage renal disease patient with documented hematocrit less than 33 (or hemoglobin less than 11)

**G8080:** Clinician documented that end-stage renal disease patient was not an eligible candidate for hematocrit (hemoglobin) measure

Denominator:

*Patients with end-stage renal disease as listed:*

CPT: G0308-G0327, 90945, 90947

**Or**

585.6 (End-stage renal disease)

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 is used or the listed CPT services or ICD-9 are provided to patients with end stage renal disease on hemodialysis. This measure is anticipated to reflect the services provided for the primary management of end stage renal disease. It is not anticipated that this measure would be applicable for services not related to the primary management of end stage renal disease.



Numerator:

**G8081:** End-stage renal disease patient requiring hemodialysis vascular access documented to have received autogenous AV fistula

**G8082:** End-stage renal disease patient requiring hemodialysis documented to have received vascular access other than autogenous AV fistula

Denominator:

*Patients with end-stage renal disease on hemodialysis as listed:*

CPT: G0308-G0327, 90945, 90947, 36818-36821, 36825

**Or**

585.6 (End-stage renal disease)

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are used and the listed CPT services are provided to patients with end stage renal disease on hemodialysis. It is anticipated that the clinician providing vascular access for the patient's hemodialysis and the clinician primarily managing hemodialysis therapy would both submit this measure for their patients. It is anticipated that clinicians will still make clinical determinations at the individual level regarding whether a patient is an appropriate candidate for arteriovenous fistula placement.

Numerator:

**G8183:** Patient with heart failure and atrial fibrillation documented to be on warfarin therapy

**G8184:** Clinician documented that patient with heart failure and atrial fibrillation was not an eligible candidate for warfarin therapy measure

Denominator:

Patients with heart failure:

Hypertensive heart disease with Heart failure: 402.01, 402.11, 402.91; Hypertensive heart and renal disease with Heart failure: 404.01, 404.03, 404.11, 404.13, 404.91, 404.93; Heart Failure codes: 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9

**And**

E&M visit: 99201-99205, 99211-99215, 99241-99245 (office consultation); 99341-99350 (home visit); 99218-99220 (observation); 99234-99236 (observation or inpatient); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337(domiciliary); 99221-99223

**And**

Atrial fibrillation 427.31

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes for heart failure and atrial fibrillation are used with the listed CPT services. This measure should reflect the quality of the services for the management of atrial fibrillation for a patient with heart failure.

Numerator:

**G8093:** Newly diagnosed chronic obstructive pulmonary disease (COPD) patient documented to have received smoking cessation intervention, within 3 months of diagnosis,

**G8094:** Newly diagnosed chronic obstructive pulmonary disease (COPD) patient not documented to have received smoking cessation intervention, within 3 months of diagnosis

Denominator:

*Patients with COPD:*

ICD-9: 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9 (Chronic bronchitis); 492.0, 492.8 (Emphysema); 494.0, 494.1 (Bronchiectasis); 496 (COPD); 493.20 – 493.22 (COPD with chronic obstructive asthma)

**And**

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99341-99350 (home visit); 99324-99328, 99334-99337 (domiciliary); 99304-99306, 99307-99310 (nursing facility); G0375; G0376

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are used and the listed E&M services are provided to patients with documented COPD.

Numerator:

**G8099:** Osteoporosis patient documented to have been prescribed calcium and vitamin D supplements

**G8100:** Clinician documented that osteoporosis patient was not an eligible candidate for calcium and vitamin D supplement measure

Denominator:

*Patients with Osteoporosis as listed:*

ICD-9: 733.00, 733.01, 733.02, 733.03, 733.09

**And**

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337(domiciliary); 99341-99350 (home visit)

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed E&M services are provided for a patient with osteoporosis. It is anticipated that this measure reflects the services provided for the primary management of osteoporosis.

Numerator:

**G8103:** Newly diagnosed osteoporosis patients documented to have been treated with antiresorptive therapy and/or parathyroid hormone treatment within 3 months of diagnosis

**G8104:** Clinician documented that newly diagnosed osteoporosis patient was not an eligible candidate for antiresorptive therapy and/or parathyroid hormone treatment measure within 3 months of diagnosis

Denominator:

*Patients with Osteoporosis:*

ICD-9: 733.00 733.01 733.02 733.03 733.09

**And**

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary); 99341-99350 (home visit)

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed E&M services are provided for a patient with osteoporosis. It is anticipated that this measure reflects the services provided for the primary management of osteoporosis.

Numerator:

**G8106:** Within 6 months of suffering a nontraumatic fracture, female patient 65 years of age or older documented to have undergone bone mineral density testing or to have been prescribed a drug to treat or prevent osteoporosis

**G8107:** Clinician documented that female patient 65 years of age or older who suffered a nontraumatic fracture within the last 6 months was not an eligible candidate for measure to test bone mineral density or drug to treat or prevent osteoporosis

Denominator:

*Female patients 65 and older with osteoporosis:*

ICD-9: 733.00 733.01 733.02 733.03 733.09

**And**

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary); 99341-99350 (home visit)

**And**

Female patients 65 and older with osteoporosis

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed CPT services are provided for an elderly female patient with nontraumatic fracture. This measure should reflect quality of services for the detection of osteoporosis related complications in the elderly female population. It is anticipated that the clinician who provides primary management of the patient would submit this measure.

Numerator:

**G8185:** Patients diagnosed with symptomatic osteoarthritis with documented annual assessment of function and pain

**G8186:** Clinician documented that symptomatic osteoarthritis patient was not an eligible candidate for annual assessment of function and pain measure

Denominator:

*Visits for patients with Osteoarthritis as listed:*

ICD-9: 715.00-715.98 (OA)

**And**

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary); 99341-99350 (home visit)

Instructions:

This measure is reported whenever the listed ICD-9 codes are used and the listed CPT services are provided for a patient with symptomatic osteoarthritis. This indicator, as well as other indicators related to assessments, should be provided only on an annual basis. This measure should reflect quality of services for the primary management of osteoarthritis.

**Measure: Influenza Vaccination**

Numerator:

**G8108:** Patient documented to have received influenza vaccination during influenza season

**G8109:** Patient not documented to have received influenza vaccination during influenza season

**G8110:** Clinician documented that patient was not an eligible candidate for influenza vaccination measure

Denominator:

*Patients 50 years of age or older:*

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary); 99341-99350; G0008

**And**

Patients 50 years of age or older

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to patients for the purpose of providing preventive services. This indicator should be provided only on an annual basis.

**Measure: Mammogram**

Numerator:

**G8111:** Patient (female) documented to have received a mammogram during the measurement year or prior year to the measurement year

**G8112:** Patient (female) not documented to have received a mammogram during the measurement year or prior year to the measurement year

**G8113:** Clinician documented that female patient was not an eligible candidate for mammography measure

**G8114:** Clinician did not provide care to patient for the required time of mammography measure (i.e., measurement year or prior year)

Denominator:

*Women age 40 or over.*

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary); 99341-99350 (home visit); G0344

**And**

Female patients age 40 or over

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to patients for the purpose of providing preventive services. This indicator should be provided only on an annual basis.



Numerator:

**G8115:** Patient documented to have received pneumococcal vaccination

**G8116:** Patient not documented to have received pneumococcal vaccination

**G8117:** Clinician documented that patient was not an eligible candidate for pneumococcal vaccination measure

Denominator:

*Patients 65 years of age or older.*

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary); 99341-99350; G0009, G0344

**And**

Patients 65 years of age or older

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to patients for the purpose of providing preventive services. This indicator shall not be reported more than once a year.

**Numerator:**

**G8126:** Patient documented as being treated with antidepressant medication during the entire 12 week acute treatment phase

**G8127:** Patient not documented as being treated with antidepressant medication during the entire 12 weeks acute treatment phase

**G8128:** Clinician documented that patient was not an eligible candidate for antidepressant medication during the entire 12 week acute treatment phase measure

**Denominator:**

*Patients 18 years and older diagnosed with a New Episode of MDD (major depression) and treated with antidepressant medication:*

E&M Visit: 99201-99205, 99211-99215; psychiatry: 90801, 90804-90809

**And**

ICD-9 296.2, 296.3, 300.4, 309.1, 311 (major depression)

**Instructions:**

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the patient is placed on prescription therapy for the treatment of a new episode of major depression disorder. It is anticipated that the clinician that provides the primary management of depression for the patient would submit this measure.

**Numerator:**

**G8129:** Patient documented as being treated with antidepressant medication for at least 6 months continuous treatment phase

**G8130:** Patient not documented as being treated with antidepressant medication for at least 6 months continuous treatment phase

**G8131:** Clinician documented that patient was not an eligible candidate for antidepressant medication for continuous treatment phase

**Denominator:**

*Patients 18 years and older diagnosed with a New Episode of MDD (major depression) and treated with antidepressant medication.*

E&M Visit: 99201-99205, 99211-99215; psychiatry: 90801, 90804-90809

**And**

ICD-9 296.2, 296.3, 300.4, 309.1, 311 (major depression)

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the patient is placed on prescription therapy for the treatment of a new episode of major depression disorder. This measure is anticipated to reflect that the primary management of the acute treatment for depression including continuous treatment (beyond 12 weeks) where clinically appropriate.

Numerator:

**G8152:** Patient documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)

**G8153:** Patient not documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)

**G8154:** Clinician documented that patient was not an eligible candidate for antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin) measure

Denominator:

*Patients with selected surgical procedures as listed:*

Musculoskeletal: 27130, 27125, 27138, 27437, 27445, 27446

Cardiovascular System: 33300 33305 33400 33401 33403 33404 33405 33406 33410 33411 33412 33413  
33414 33415 33416 33417 33420 33422 33425 33426 33427 33430 33460 33463 33464 33465 33468  
33470 33471 33472 33474 33475 33476 33478 33496 33510 33511 33512 33513 33514 33516 33517  
33518 33519 33521 33522 33523 33530 33533 33534 33535 33536 33545 33560 33600 33602 33608  
33610 33611 33612 33615 33617 33619 33641 33645 33647 33660 33665 33670 33681 33684 33688  
33692 33694 33697 33702 33710 33720 33722 33730 33732 33735 33736 33737 33770 33771 33774  
33775 33776 33777 33778 33779 33780 33781 33786 33813 33814 33875 33877 33918 33919 33920  
33924 33999 34520 34830 34831 34832 35081 35082 35091 35092 35102 35103 35111 35112 35121  
35122 35131 35132 35141 35142 35151 35152 35256 35286 35331 35341 35351 35355 35361 35363  
35371 35372 35381 35516 35518 35521 35522 35525 35531 35533 35536 35541 35546 35548 35549  
35551 35556 35558 35563 35565 35566 35571 35583 35585 35587 35600 35616 35621 35623 35631  
35636 35641 35646 35647 35650 35651 35654 35656 35661 35665 35666 35671 35686 35879 35881  
35903 35907 37500 37700 37720 37730 37735 37760 37765 37766 37780 37785 37788 37791 92992  
92993 93580 93581

Hemic and Lymphatic Systems: 38082 38103

Digestive System: 44025 44110 44111 44120 44121 44125 44130 44139 44140 44141 44143 44144  
44145 44146 44147 44150 44151 44152 44153 44155 44156 44160 44204 44205 44206 44207 44208  
44210 44211 44212 44300 44320 44322 44604 44605 44615 44625 44626 44660 44661 44799 45110  
45111 45112 45113 45114 45116 45119 45120 45121 45123 45126 45130 45135 45550 45562 45563  
45800 45805 45820 45825 45999

Urinary System: 51597 51925

Female Genital System: 57307 58150 58152 58180 58200 58210 58240 58260 58262 58263 58285 58550  
58552 58553 58554 58951 58953 59135 59136 59140 59525

**Instructions:**

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided for a patient undergoing surgery that typically requires the administration of prophylactic antibiotics. It is anticipated that this measure should reflect the management of the surgical patient to reduce complications from infections. Thus, it is anticipated that it may be appropriate for both the clinician performing the surgery and the clinician providing anesthesia services may submit this measure for a patient.

**Numerator:**

**G8155:** Patient with documented receipt of thromboembolism prophylaxis

**G8156:** Patient without documented receipt of thromboembolism prophylaxis

**G8157:** Clinician documented that patient was not an eligible candidate for thromboembolism prophylaxis measure

**Denominator:**

*Patients with selected surgical procedures as listed:*

Integumentary System: 13160

Musculoskeletal System: 20102 22554 22556 22558 22585 22590 22600 22612 22614 22800 22802  
22804 22808 22810 22812 22840 22851 27120 27125 27130 27132 27134 27137 27138 27236 27437  
27445 27446 27447 27486 27487

Respiratory System: 32140 32141 32220 32225 32310 32320 32440 32442 32445 32480 32482 32484  
32486 32488 32520 32522 32525 32651 32652 32655 32656 32663 32800 32850

Cardiovascular System: 33930 35840 35870 37799

Hemic and Lymphatic Systems: 38100 38101 38102 38120

Mediastinum and Diaphragm: 39501 39502 39503 39520 39530 39531 39540 39541 39545 39560 39561  
39599

Digestive System: 42953 43020 43045 43107 43108 43112 43113 43116 43117 43118 43121 43122  
43123 43124 43228 43240 43250 43251 43258 43267 43268 43269 43271 43272 43280 43289 43300  
43305 43310 43312 43313 43314 43316 43320 43324 43325 43326 43340 43341 43350 43351 43352  
43360 43361 43401 43405 43410 43415 43420 43425 43496 43499 43500 43501 43502 43510 43620

43621 43622 43631 43632 43633 43634 43635 43638 43639 43640 43641 43652 43761 43800 43810  
43820 43825 43840 43842 43843 43845 43846 43847 43848 43850 43855 43860 43865 43870 43880  
43999 44005 44010 44015 44020 44021 44025 44050 44055 44110 44111 44120 44121 44125 44126  
44127 44128 44130 44132 44133 44139 44140 44141 44143 44144 44145 44146 44147 44150 44151  
44152 44153 44155 44156 44160 44201 44202 44203 44204 44205 44206 44207 44208 44210 44211  
44212 44300 44310 44316 44320 44322 44340 44345 44346 44351 44370 44379 44383 44397 44602  
44603 44604 44605 44615 44620 44625 44626 44640 44650 44660 44661 44680 44700 44799 44800  
44820 44850 45000 45005 45020 45110 45111 45112 45113 45114 45116 45119 45120 45121 45123  
45126 45130 45135 45136 45160 45170 45321 45327 45345 45387 45500 45505 45540 45541 45550  
45562 45563 45800 45805 45820 45825 45999 46730 46735 46744 46746 46748 47010 47011 47120  
47122 47125 47130 47133 47300 47315 47350 47360 47361 47362 47370 47371 47380 47381 47382  
47399 47400 47420 47425 47460 47510 47511 47564 47570 47579 47610 47612 47620 47716 47720  
47721 47740 47741 47760 47765 47780 47785 47800 47802 47900 47999 48000 48001 48005 48020  
48120 48140 48145 48146 48148 48150 48151 48152 48153 48154 48155 48160 48180 48500 48510  
48511 48520 48540 48545 48547 48550 48554 48556 48662 48999 49002 49020 49021 49040 49041  
49060 49061 49080 49081 49085 49201 49210 49215 49220 49255 49420 49421 49425 49426 49605  
49606 49610 49611 49900 49904 49906 49999 96445

Urinary System:

50020 50021 50220 50223 50225 50230 50234 50236 50240 50300 50320 50340 50360 50365 50370  
50380 50543 50545 50546 50547 50548 50562 50715 50722 50725 50727 50728 50760 50770 50780  
50782 50783 50785 50800 50810 50815 50820 50947 50948 51314 51550 51555 51565 51570 51575  
51580 51585 51590 51595 51596 51597 51800 51820 51860 51865 51880 51900 51920 51925 51940  
51960 52355 53899

Male Genital System: 54380 54385 54390 54595 55810 55812 55815 55821 55831 55840 55842 55845  
55866

Female Genital System: 57307 57330 57531 58150 58152 58180 58200 58210 58240 58260 58262 58263  
58285 58291 58292 58550 58552 58553 58554 58661 58662 58679 58700 58720 58823 58920 58925  
58940 58943 58950 58951 58952 58953 58954 58960 58999  
59120 59121 59135 59136 59140 59150 59151 59154 59525

Endocrine System: 60540 60545

Nervous System: 61105 61107 61108 61120 61150 61151 61154 61156 61210 61250 61253 61304 61305  
61312 61313 61314 61315 61320 61321 61322 61323 61330 61332 61333 61340 61345 61437 61440  
61470 61480 61490 61510 61512 61514 61516 61518 61519 61520 61521 61522 61524 61526 61530  
61534 61536 61537 61538 61539 61540 61541 61542 61543 61545 61556 61557 61570 61571 61575  
61576 61580 61581 61582 61583 61584 61585 61586 61590 61591 61592 61595 61598 61600 61601  
61605 61606 61607 61608 61615 61616 61720 61735 61770 61800 62000 62005 62010 62161 62162  
62163 62164 64752 64755 64760 64999

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services codes are provided to a surgical patient. This measure should reflect the quality of the services provided

for surgical patients to prevent the complications of thromboembolism. It is anticipated that the clinician providing primary management of the surgical patient would submit this measure. It is anticipated that thromboembolism prophylaxis includes low-dose unfractionated heparin, low molecular weight heparin, graduated compression stockings, intermittent pneumatic compression devices, factor Xa inhibitor and warfarin. The appropriate use of thromboembolism prophylaxis will vary according to the surgical procedure.

**Numerator:**

**G8158:** Patient documented to have received coronary artery bypass graft with use of internal mammary artery

**G8159:** Patient documented to have received coronary artery bypass graft without use of internal mammary artery

**G8160:** Clinician documented that patient was not an eligible candidate for coronary artery bypass graft with use of internal mammary artery measure

**Denominator:**

*Patients with coronary artery bypass graft using internal mammary artery:*

CPT: 33533, 33534, 33535, 33536

**Instructions:**

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided for a patient undergoing coronary artery bypass graft surgery. This measure is intended to reflect the quality of the surgical services provided for CABG patients.

**Numerator:**

**G8161:** Patient with isolated coronary artery bypass graft documented to have received pre-operative beta-blockade

**G8162:** Patient with isolated coronary artery bypass graft not documented to have received pre-operative beta-blockade

**G8163:** Clinician documented that patient with isolated coronary artery bypass graft was not an eligible candidate for pre-operative beta-blockade measure

**Denominator:**

*Patients with Coronary artery bypass graft as listed:*

CPT: 33510, 33511, 33512, 33513, 33514, 33516, 33533, 33534, 33535, 33536

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided for a patient undergoing coronary artery bypass graft surgery. This measure should reflect the primary management of the surgical patient undergoing isolated coronary artery bypass surgery.

Numerator:

**G8164:** Patient with isolated coronary artery bypass graft documented to have prolonged intubation

**G8165:** Patient with isolated coronary artery bypass graft not documented to have prolonged intubation

Denominator:

*Patients with coronary artery bypass graft as listed:*

CPT: 33510, 33511, 33512, 33513, 33514, 33516, 33533, 33534, 33535, 33536

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided for a patient undergoing isolated coronary artery bypass graft surgery. This measure should reflect the management of the surgical patient undergoing coronary artery bypass graft surgery. This measure is not intended to encourage the inappropriate early extubation of patients. The treating clinician should continue to make the appropriate clinical determination regarding the necessity for intubation.

Numerator:

**G8166:** Patient with isolated coronary artery bypass graft documented to have required surgical re-exploration

**G8167:** Patient with isolated coronary artery bypass graft did not require surgical re-exploration

Denominator:

*Patients with coronary artery bypass graft as listed:*

CPT: 33510, 33511, 33512, 33513, 33514, 33516, 33533, 33534, 33535, 33536

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided for a patient undergoing coronary artery bypass graft surgery. It is anticipated that there may be clinical reasons for a patient to undergo re-exploration. This measure is not anticipated to discourage the treating physician from making the appropriate clinical decision for surgical re-exploration.



Numerator:

**G8170:** Patient with isolated coronary artery bypass graft documented to have been discharged on aspirin or clopidogrel

**G8171:** Patient with isolated coronary artery bypass graft not documented to have been discharged on aspirin or clopidogrel

**G8172:** Clinician documented that patient with isolated coronary artery bypass graft was not an eligible candidate for antiplatelet therapy at discharge measure

Denominator:

*Patients with* coronary artery bypass graft:

CPT: 33510, 33511, 33512, 33513, 33514, 33516, 33533, 33534, 33535, 33536

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided for a patient undergoing coronary artery bypass graft surgery. This measure should reflect the primary management of the surgical patient undergoing isolated coronary artery bypass surgery.